# Sylvia Park Rest Home Limited - Sylvia Park Rest Home & Hospital

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to Manatū Hauora (the Ministry of Health).

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora website by clicking here.

The specifics of this audit included:

**Legal entity:** Sylvia Park Rest Home Limited

**Premises audited:** Sylvia Park Rest Home & Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 8 December 2025 End date: 9 December 2025

**Proposed changes to current services (if any):** None.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 81

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou motika │ our rights
- hunga mahi me te hanganga │ workforce and structure
- ngā huarahi ki te oranga │ pathways to wellbeing
- te aro ki te tangata me te taiao haumaru │ person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita │ infection prevention and antimicrobial stewardship
- here taratahi │ restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| Indicator | Description | Definition |
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| | Includes commendable elements above the required levels of performance | All subsections applicable to this service are fully attained with some subsections exceeded |
| | No short falls | Subsections applicable to this service are fully attained |
| | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some subsections applicable to this service are partially attained and of low risk |

| Indicator | Description | Definition |
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|  | A number of shortfalls that require specific action to address | Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some subsections applicable to this service are unattained and of moderate or high risk |

## General overview of the audit

Sylvia Park Rest Home and Hospital provides hospital (medical and geriatric), and rest home level of care for up to 82 residents. There were 81 residents on the days of audit.

This surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Standard 2021 and contracts with Health New Zealand. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family/whānau, management and staff.

The facility manager/owner is appropriately qualified and experienced and is supported by an assistant manager and clinical nurse manager (registered nurse).

There are documented quality and risk management systems and processes. Feedback from family/whānau was positive about the care and the services provided. An induction and in-service training programme is documented through policies to provide staff with appropriate knowledge and skills to deliver care.

The previous audit findings related to care plan interventions and aspects of medication management have not been addressed.

This surveillance audit identified shortfalls related to consent, adverse events, staff training, monitoring of care, the food service, the environment, outbreak processes. Subsection 5.5 has been opened to address shortfalls identified around the use of chemicals and environmental cleanliness.

## Ō tātou motika | Our rights

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| Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs. | | Some subsections applicable to this service are partially attained and of low risk. |

A Māori health plan is in place for the organisation. Māori mana Motuhake is recognised in service delivery, using a strengths-based and holistic model of care. Staff encourage participation in te ao Māori.

A pacific health plan is in place which ensures cultural safety for Pacific peoples, embracing their worldviews, cultural and spiritual beliefs.

Policies are in place around the elimination of discrimination, harassment, and bullying. There is an established system for the management of complaints that is responsive, fair, equitable and meets guidelines established by the Health and Disability Commissioner.

## Hunga mahi me te hanganga | Workforce and structure

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| Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce. | | Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk. |

The business plan includes a mission statement and operational objectives. The service has a quality and risk management system in place that take a risk-based approach. Internal audits, and collation of data were all documented as taking place as scheduled, with corrective actions as indicated.

There is a staffing and rostering policy that aims to manage human resources in accordance with good employment practice. An orientation programme and staff training plan are in place to support staff in delivering safe quality care.

## Ngā huarahi ki te oranga | Pathways to wellbeing

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| Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs. | | Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk. |

The clinical nurse manager assesses residents on admission. InterRAI assessments and risk assessments are used to identify residents' needs, and long-term care plans are developed. Residents who identify as Māori or Pasifika have their needs met in a manner that respects their cultural values and beliefs. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Residents' food preferences and dietary requirements are identified at admission, and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. The service has a current food control plan.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent caregivers are responsible for administration of medicines. They complete annual education and medication competencies. The electronic medicine charts reviewed are reviewed at least three-monthly by the general practitioner.

Discharge and transfers are coordinated and planned.

## Te aro ki te tangata me te taiao haumaru | Person-centred and safe environment

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| Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities. | | Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk. |

There is a Building Warrant of Fitness Report and Declaration (B-RaD) in place. Maintenance requests are logged and followed up in a timely manner.

## Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

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| Includes five subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance. | | Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk. |

Infection prevention management systems are in place to minimise the risk of infection to residents, staff, and visitors. The documented infection control programme identifies the needs of the organisation and provides information and resources to inform service providers.

Staff complete education in relation to infection control during orientation. There is a training plan that includes infection prevention and control.

Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. There have been no outbreaks recorded since the last audit.

## Here taratahi | Restraint and seclusion

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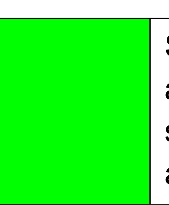
| Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained. |  | Subsections applicable to this service are fully attained. |

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by a registered nurse. At the time of the audit there were three residents using physical restraints. Staff demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques, and alternative interventions.

## Summary of attainment

The following table summarises the number of subsections and criteria audited and the ratings they were awarded.

| **Attainment Rating** | **Continuous Improvement (CI)** | **Fully Attained (FA)** | **Partially Attained Negligible Risk (PA Negligible)** | **Partially Attained Low Risk (PA Low)** | **Partially Attained Moderate Risk (PA Moderate)** | **Partially Attained High Risk (PA High)** | **Partially Attained Critical Risk (PA Critical)** |
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| **Subsection** | 0 | 10 | 0 | 2 | 7 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 3 | 11 | 0 | 0 |

| **Attainment Rating** | **Unattained Negligible Risk (UA Negligible)** | **Unattained Low Risk (UA Low)** | **Unattained Moderate Risk (UA Moderate)** | **Unattained High Risk (UA High)** | **Unattained Critical Risk (UA Critical)** |
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| **Subsection** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Ngā paerewa Health and disability services standard

The following table contains the results of all the subsections assessed by the auditors at this audit.  Depending on the services they provide, not all subsections are relevant to all providers and not all subsections are assessed at every audit.

For more information on the standard, please click here.

For more information on the different types of audits and what they cover please click here.

| Subsection with desired outcome | Attainment Rating | Audit Evidence |
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| Subsection 1.1: Pae ora healthy futures<br><br>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.<br>As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi. | FA | A Māori health plan is documented for the service, which Sylvia Park Rest Home and Hospital utilises as part of their strategy to embed and enact Te Tiriti o Waitangi in all aspects of service delivery. The service currently has residents who identify as Māori. There were no staff who identified as Māori at the time of the audit. The service recognises Māori mana Motuhake, and this is reflected in the Māori health plan. |
| Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa<br><br>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.<br>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.<br>As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes. | FA | There is a Pacific health plan which aligns to Ola Manuia Pacific Health and Wellbeing Action Plan 2020-2025. The focus is on fostering Pacific community integration and collaboration to enable better planning, support interventions, and evaluations of the health and wellbeing of Pacific peoples to improve outcomes. At the time of the audit there were residents and staff who identified as Pasifika and they supported the service in understanding worldviews, cultural and spiritual beliefs of Pacific peoples. |

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| Subsection 1.3: My rights during service delivery<br><br>The People: My rights have meaningful effect through the actions and behaviours of others.<br>Te Tiriti:Service providers recognise Māori mana motuhake (self-determination).<br>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements. | FA | The Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) is displayed in English and te reo Māori. The assistant manager and clinical nurse manager demonstrated how it is also given in welcome packs in the language most appropriate for the resident to ensure they are fully informed of their rights. Interviews with two rest home level of care family/whānau, and four residents (two hospital level, two rest home level) confirmed they are informed of their rights and their choices are respected. Interactions observed between staff and residents during the audit were respectful. |
| Subsection 1.5: I am protected from abuse<br><br>The People: I feel safe and protected from abuse.<br>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.<br>As service providers: We ensure the people using our services are safe and protected from abuse. | FA | Sylvia Park Rest Home and Hospital policies provide guidelines that aim to prevent any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. A comprehensive code of conduct is discussed and signed by staff during their induction to the service. The code of conduct addresses harassment, racism, and bullying. Staff sign to acknowledge that they accept the code of conduct as part of the employment process.<br><br>The service implements a process to manage residents’ comfort funds, such as sundry expenses. . All family/whānau interviewed confirmed that the staff are very caring, supportive, and respectful. They further confirmed that the resident’s property and finances are respected and managed.<br><br>Professional boundaries are defined in job descriptions. Interviews with registered nurses and caregivers confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation.<br><br>Interviews with nine staff (five caregivers, two registered nurses, one cook, one cleaner), the facility manager/owner, assistant manager, clinical nurse manager, residents, family/whānau and documentation reviewed, confirmed that the staff are very caring, supportive, and respectful. |

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| Subsection 1.7: I am informed and able to make choices<br><br>The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.<br>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health,<br>keep well, and live well.<br>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control. | PA Low | There are policies around informed consent documented for Sylvia Park Rest Home and Hospital. Resident files reviewed included completed general consent forms and consents for influenza and Covid-19 vaccinations. However not all consents for shared rooms were completed. Residents and family/whānau interviewed could describe what informed consent was and knew they had the right to choose. Admission agreements and consent forms were appropriately signed by the resident or the activated enduring power of attorney (EPOA) where this has been activated. All documentation regarding EPOA and activation is on file. |
| Subsection 1.8: I have the right to complain<br><br>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.<br>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.<br>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement. | FA | The complaints procedure is provided to residents and family/whānau during the resident’s entry to the service. Access to complaints forms is located at the entrance to the facility or on request from staff. The Code of Health and Disability Services Consumers’ Rights and complaints process is visible, and available in te reo Māori, Chinese and English. A complaints register is being maintained which includes all complaints, dates and actions taken. There have been no complaints made since last audit. The assistant manager is responsible for the management of complaints. An interview with the assistant manager confirmed their awareness of the complaints process in line with the guidelines set out by Health and Disability Commissioner (HDC).<br><br>Residents or family/whānau making a complaint can involve an independent support person in the process if they choose. The complaints process is linked to advocacy services. Discussions with residents and family/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had, were addressed promptly. Information about the support resources for Māori is available to staff to assist Māori in the |

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|  |  | complaints process. Interpreters contact details are available. The assistant manager acknowledged their understanding that for Māori, there is a preference for face-to-face communication and to include family/whānau participation. |
| Subsection 2.1: Governance<br><br>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.<br>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.<br>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve. | FA | Sylvia Park Rest Home and Hospital provides rest home and hospital (medical and geriatric) levels of care for up to 82 beds. All the beds are certified dual purpose. There are six double rooms. On the day of audit, there were 81 residents: ten at rest home level and 71 at hospital level including two on younger person with disability (YPD) contract. The remaining residents were under the age-related residential care (ARRC) agreement.<br><br>Sylvia Park Rest Home and Hospital is the trading name of Sylvia Park Rest Home Limited - a privately owned company with two directors. It is one of two facilities owned and operated by the directors. Sylvia Park Home and Hospital has a current business plan in place with clear goals to support their documented vision, mission, and values. The values espouse caring, and personalised care. The facility manager/owner interviewed on the day of the audit was knowledgeable around legislative and contractual requirements and is experienced in the aged care sector, having owned and managed aged care facilities for a number of years. The clinical nurse manager and the general practitioner provide oversight with clinical governance.<br><br>A mission, philosophy and objectives are documented for the service. The monthly staff meetings provide an opportunity to review the day-to-day operations and to review progress towards meeting the business objectives. The management team analyse internal processes, business planning, and service development to improve outcomes for residents and have processes in place to achieve equity for Māori; and to identify and address barriers for Māori for equitable service delivery. This includes input from a Māori cultural advisor as required. The annual resident survey evidenced improved outcomes and equity for tāngata whaikaha people with disabilities. Collaboration with residents and whānau who identify as Māori and/or tāngata whaikaha reflect their input for the provision of equitable delivery of care. |

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| | | The day-to-day operations are overseen by the assistant manager (non-clinical) who has been in the role for over 10 years. They are supported by a clinical nurse manager (a registered nurse with a current practicing certificate), who has been in the role for seven years. The facility manager/owner is hands on and involved in the operations and oversight of the two facilities. The management is supported by a team of registered nurses, caregivers, cleaning, laundry, activities, and kitchen staff.<br><br>The assistant manager and clinical nurse manager have maintained the required hours of professional development activities related to managing an aged care facility, including (but not limited to) understanding dementia, motor neurone disease, admissions and discharges, Poi programme with hospice, mental health, Treaty of Waitangi. |
| Subsection 2.2: Quality and risk<br><br>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.<br>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.<br>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers. | PA Moderate | A quality and risk management programme is documented. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Monthly staff meetings provide an avenue for discussions in relation to (but not limited to) quality data; health and safety; infection control/pandemic strategies; complaints received (if any); staffing; and education. Internal audits and collation of data were documented as taking place in 2025 and were completed in 2024. Completed internal audits identify corrective actions are documented where indicated to address service improvements. Corrective actions provide evidence of progress and sign off when achieved. A meeting schedule for 2024 / 2025 has been documented, and meetings have been held according to the schedule including resident and family/whānau meetings.<br><br>Quality objectives have been documented for 2024 and 2025 with milestone measures of progress documented and signed off when completed. Resident and family/whānau satisfaction surveys completed for 2025 demonstrated a satisfaction with all aspects of service delivery. Comments added to the satisfaction surveys were positive.<br><br>Policies and procedures are held electronically and in hard copy. Staff |

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| | | interviewed confirmed they were able to access policies and relevant documentation, as and when required.<br><br>A health and safety system is in place. Hazard identification forms are completed electronically, and an up-to-date hazard and risk register was reviewed (sighted). Staff are kept informed on health and safety issues in handovers and meetings. Electronic entries have not been completed for each incident/accident. When completed immediate action is documented with any follow-up action(s) required. This was evidenced in a sample of ten accident/incident records reviewed. However, these are not linked to the Severity Assessment Code (SAC) as per policy and have not consistently been evaluated and closed off. Incident and accident data is collated monthly and analysed. Results are discussed in the staff meetings and at handover. Each event involving a resident reflected a clinical assessment and a timely follow up by a registered nurse. Neurological observations were not always completed as per policy (link 3.2.4).<br><br>Discussions with the assistant manager and clinical nurse manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been no Section 31 notifications and at the time of the audit the service did not have a log in for Severity Assessment Code (SAC) notifications to the Health Quality and Safety Commission. There have been no outbreaks documented since the previous audit. |
| Subsection 2.3: Service management<br><br>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.<br>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.<br>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services. | PA Moderate | There is a staffing policy that describes rostering requirements for Sylvia Park Rest Home and Hospital. The roster reviewed showed that there is 24/7 registered nurse cover sufficient and appropriate for the effective delivery of care and support for rest home and hospital level care residents. The number of caregivers on each shift is sufficient for the acuity and layout of the facility to provide safe and timely care on all shifts.<br><br>Staff and residents are informed when there are changes to staffing levels, evidenced in staff interviews. Staff absences are covered by own staff and casuals as sighted on the roster and on the days of the audit. The assistant manager and clinical nurse manager work full time |

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|  |  | Monday to Friday, between Sylvia Park and the sister facility. The clinical nurse manager and general practitioner are available on call 24/7 for any clinical concerns and the assistant manager provides on call for non-clinical issues 24/7.<br><br>There is a documented 2024 and 2025 education and training schedule. The education and training schedule lists compulsory training which includes cultural awareness training and topics related to caring for the older person. However, the education and training schedule has not been completed as scheduled for staff. Training schedule includes (but not limited to) topics related to dehydration and nutrition, restraint management, infection control and outbreak management, falls prevention, care/hygiene and skin management, pressure injuries, fire training, manual handling, preventing dementia, cultural safety, complaints and open disclosure, safe food handling and spirituality, sexuality and intimacy.<br><br>External training opportunities for care staff include training through Health New Zealand and hospice. The service supports and encourages caregivers to obtain a New Zealand Qualification Authority (NZQA) qualification. Twenty-one caregivers are employed. Of the 21 caregivers at Sylvia Park Rest Home and Hospital, 10 have achieved a level 3 NZQA qualification or higher.<br><br>All staff are required to complete competency assessments as part of their orientation and annually. The organisation’s orientation programme ensures core competencies and compulsory knowledge/topics are addressed. Records reviewed show that all staff have completed the required competencies. Registered nurses have current medication competencies. All the six registered nurses (including clinical nurse manager) are interRAI trained. All registered nurses are encouraged to attend in-service training and complete additional training, including critical thinking; infection prevention and control, including Covid-19 preparedness and identifying and assessing the unwell resident. However, there is no evidence that this has been completed. A record of completion is maintained on an electronic spreadsheet and staff personnel file. |

| Subsection 2.4: Health care and support workers<br><br>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.<br>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.<br>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services. | FA | Five staff files reviewed included evidence of completed orientation, competencies and professional qualifications on file where required. There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. A register of practising certificates is maintained for all health professionals including (but not limited to) registered nurses, general practitioner, pharmacists, podiatrist, physiotherapist, and dietitian.<br><br>The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. The service demonstrates that the orientation programmes support registered nurses and caregivers to provide a culturally safe environment to Māori. Staff who have been employed for a year or more have a current performance appraisal on file. |
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| Subsection 3.2: My pathway to wellbeing<br><br>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.<br>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.<br>As service providers: We work in partnership with people and whānau to support wellbeing. | PA Moderate | The clinical nurse manager and registered nurses are responsible for all residents' assessments, care planning, and evaluation of care. Six resident files were reviewed: four hospital level including one younger person, and two at rest home level, Care plans evidenced initial care plans are developed in partnership with the residents/EPOA within the required timeframe. There is documented evidence of resident, EPOA or family/whānau involvement in care-planning. Care plans are based on data collected during the initial nursing assessments.<br><br>The individualised electronic long-term care plans are developed with information gathered during the initial assessments and the interRAI assessment. All long-term care plans and interRAI assessments sampled had been completed within three weeks of the residents' admission to the service. Assessments and care plans are documented by the registered nurses. The care plans are individualised and reflect resident preferences; however, not all care plan interventions were documented in sufficient detail to guide the resident needs. This is a continued short fall from the previous audit. Short term care plans are developed for short term needs such as infections, and additional resident needs such as feeding regimes. |

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| | | The initial medical assessment is undertaken by the general practitioner (GP) within the required timeframe following admission. There is evidence in files of the requirement to have monthly (hospital residents) or three-monthly (rest home) GP reviews/visits when the resident’s condition is considered stable. The contracted GP visits the facility weekly. Residents have reviews by the GP within required timeframes and when their health status changes. The GP was unable to be interviewed on the day of audit. The GP practice provides an after-hours service to the facility. A physiotherapist visits the facility weekly.<br><br>Contact details for family are recorded in the clinical file. Resident records evidenced that family are informed where there is a change in health status.<br><br>There was evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken where this was required. Wounds included skin tears, lesions, chronic ulcers, and abrasions. There was evidence that if wounds required additional specialist input, this was initiated, and a wound nurse specialist consulted.<br><br>Caregivers interviewed could describe a verbal and written handover at the beginning of each shift that maintains a continuity of service delivery, as observed on the day of audit, and was found to be comprehensive in nature. Progress notes are written each shift and as necessary by caregivers and the facility manager. When changes occur with the residents’ health, these are reflected in the progress notes to provide an evolving picture of the resident journey. When a resident’s condition alters, the clinical nurse manager initiates a review with the GP. There was evidence the facility manager had added to the progress notes when there was an incident and or change in health status.<br><br>A range of monitoring charts are available for staff to utilise. Monitoring charts reviewed were not all completed as required. Long-term care plans are formally evaluated every six months in conjunction with the interRAI re-assessments and when there is a change in the resident’s condition. Evaluations include the degree of achievement towards meeting desired goals and outcomes, are documented by the |

| | | registered nurses. |
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| Subsection 3.4: My medication<br><br>The people: I receive my medication and blood products in a safe and timely manner.<br>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.<br>As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | An electronic medication management system was observed on the day of audit, and ten medication records were reviewed. The medication management policy identifies all aspects of medicine management in line with relevant legislation and guidelines. Prescribing practices are in line with legislation, protocols, and guidelines. Three-monthly reviews by the GP. Allergies were not always recorded in all medication charts sampled.<br><br>The service uses pharmacy pre-packaged medicines that are checked by a registered nurse on delivery to the facility. All medications sighted were within current use by dates, and eyedrops had been dated upon opening. A system is in place for returning expired or unwanted medication to the contracted pharmacy. The medication refrigerator temperatures are monitored daily and within acceptable ranges The medication room temperatures were not monitored and documented daily. Medications are stored securely in accordance with requirements.<br><br>The staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. All staff who administer medications have current competencies in place.<br><br>The clinical nurse manager oversees the use of all pro re nata (PRN) medicines and documentation made regarding effectiveness in the progress notes was sighted. This is an improvement from the previous audit. Current medication competencies were evident in staff files.<br><br>There were no residents self-administering medication on the day of the audit; policy and procedures including assessment, review, and the provision of safe storage were in place where required. Standing orders are not used, and vaccines are not kept on site. |
| Subsection 3.5: Nutrition to support wellbeing<br><br>The people: Service providers meet my nutritional needs and | PA Low | A nutritional assessment is undertaken by the registered nurses for each resident on admission to identify the residents' dietary requirements and preferences. The nutritional profiles are |

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| consider my food preferences.<br>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.<br>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing. | | communicated to the kitchen staff and updated when a resident's dietary needs change. Diets are modified as needed and the cook at interview confirmed awareness of the dietary needs, likes, dislikes and cultural needs of residents. These are accommodated in daily meal planning.<br><br>Discussion and feedback on the menu and food provided is sought at the residents' meetings and in the annual residents' survey. Residents and families interviewed stated that they were satisfied with the meals provided.<br><br>The food control plan is current and expires February 2027. Food stored in the kitchenette fridges is not consistently labelled and dated. |
| Subsection 3.6: Transition, transfer, and discharge<br><br>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.<br>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.<br>As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support. | FA | There is a documented policy that relates to resident transfer and discharge. Transition, discharge, or transfer is managed in a planned and coordinated in a timely and safe manner. Interviews with staff confirmed residents and their family/whānau were involved for all discharges to and from the service. Discharge notes are kept on file and discharge instructions are incorporated into the care plan. |
| Subsection 4.1: The facility<br><br>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.<br>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.<br>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely | PA Moderate | There is a Building Warrant of Fitness Report and Declaration (B-RaD). The management team confirmed that issues identified in this report have been rectified ( emergency lighting, the service lift, and the passenger lift). Maintenance requests are logged and followed up in a timely manner. There is an annual maintenance plan that includes a schedule of electrical testing and tagging, residents' equipment checks, call bell checks, calibration of medical equipment and monthly testing of hot water temperatures. Not all electrical items have an up-to-date test and tag, and not all medical equipment has an up-to-date calibration. Essential contractors such as plumbers and electricians are |

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| throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function. | | available 24 hours a day as required. Caregivers interviewed stated they have adequate equipment to safely deliver care for residents.<br><br>All corridors have safety rails that promote safe mobility. Corridors are spacious, and residents were observed moving freely around the areas with mobility aids where required. There is safe access to all communal areas. The service has shared rooms; one room with two residents (not related to each other) is not able to provide privacy for the individual residents in that room.<br><br>Residents are encouraged to personalise their bedrooms, including those with cultural or spiritual significance as viewed on the days of audit. |
| Subsection 5.2: The infection prevention programme and implementation<br><br>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.<br>Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant.<br>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services. | PA Moderate | The infection prevention control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, and the training and education of staff. The infection control programme is linked to the quality system. Infection control is included in the internal audit schedule. Any corrective actions identified have been implemented and signed off as resolved. The infection control programme is reviewed and reported on annually (last completed 17 January 2025).<br><br>Sylvia Park Rest Home and Hospital has a documented outbreak, pandemic, and infectious disease response plan in place. However, there are no sufficient infection prevention resources including personal protective equipment (PPE) available or readily accessible to support the documented plan.<br><br>The infection control policy states that Sylvia Park Rest Home and Hospital is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and included in the annual training plan. Staff have not completed the required annual training (link 2.3.4).<br><br>The infection control coordinator, a registered nurse, has not undertaken training to keep abreast with current best practice. They have additional support from the clinical nurse manager and expertise at Health New Zealand. |

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| Subsection 5.4: Surveillance of health care-associated infection (HAI)<br><br>The people: My health and progress are monitored as part of the surveillance programme.<br>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.<br>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus. | FA | The infection prevention control policy describes surveillance as an integral part of the infection prevention and control programme. Monthly infection data is collected for all infections based on signs, symptoms, and the definition of the infection. Infections are entered into the electronic infection register and surveillance of all infections (including organisms) is collated onto a monthly infection summary. Reports include antibiotic use. This data is monitored and analysed for trends, monthly and annually. Sylvia Park Rest Home and Hospital incorporates ethnicity data into surveillance methods and data captured around infections.<br><br>Infection control surveillance results are discussed at the monthly staff meetings. Meeting minutes and data are available for staff. Action plans are completed for any infection rates of concern. Infection control audits have been completed with corrective actions for areas of improvement implemented.<br><br>Sylvia Park Rest Home and Hospital receives regular notifications and alerts from Health New Zealand for any community concerns. There have been no outbreaks since last audited. Although there have been no outbreaks, there are well documented policies and processes to guide staff in the event of an outbreak / pandemic, including documentation, debrief and reporting requirements. |
| Subsection 5.5: Environment<br><br>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.<br>Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible.<br>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms. | PA Moderate | There are policies regarding chemical safety and waste disposal. Chemicals sighted were not consistently labelled with manufacturer's labels and were not always stored in locked areas. Cleaning chemicals are dispensed through large containers into smaller bottles for use on the trollies. Material safety data sheets (MSDS) and product sheets available were not matching the provider and labels on the chemical bottles. Sharps containers are available and meet the hazardous substances regulations for containers. Gloves and aprons are not readily available for staff. There are sluice rooms (with sanitisers); however, they did not all have personal protective equipment for staff to use. |

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| | | The service has communal toilets available in all areas for residents to access, however one of the toilets is also a sluice room.<br><br>Cleaners' trolleys are attended to at all times and locked away in the cleaners' cupboard when not in use. Outcome of the internal auditing processes demonstrates that cleaning schedules have been maintained for daily and periodic cleaning. However, inspection of the environment demonstrates that cleanliness has not been maintained.<br><br>This subsection 5.5 and criteria 5.5.1, 5.5.2, 5.5.3 have been opened to address issues related to the environment identified on the days of audit. |
| Subsection 6.1: A process of restraint<br><br>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.<br>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.<br>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination. | FA | There is a Restraint Elimination and Preventing use of Restraint policy. An RN is the restraint coordinator (RN) and provides support and oversight for restraint management in the facility. The RN interviewed is conversant with restraint policies and procedures. The restraint policy confirms that restraint consideration and application would be done in partnership with families/whānau, and the choice of device must be the least restrictive possible. At all times when restraint is considered, Silvia Park works in partnership with Māori and residents to promote and ensure services are mana enhancing.<br><br>At the time of the audit, there was three residents using restraint (two bedrails and one lap belt). The RN confirmed Silvia Park is committed to providing services to residents without use of restraint.<br><br>A review of the documentation available for the resident using restraint, include processes and resources for assessment, consent, monitoring, and evaluation (link 3.2.4) The restraint approval process includes the resident (where appropriate), EPOA, GP and restraint coordinator. Restraint minimisation is included as part of the mandatory training plan and orientation programme.<br><br>The use of restraint is reported in the combined quality and staff meetings. The reporting process includes the CNM and facility manager/owner. |

# Specific results for criterion where corrective actions are required

Where a subsection is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the subsection.  The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant subsection by looking at the code.  For example,  Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
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| Criterion 1.7.5<br>I shall give informed consent in accordance with the Code of Health and Disability Services Consumers’ Rights and operating policies. | PA Low | There are policies around informed consent documented for Sylvia Park Rest Home and Hospital. The service has a specific consent for residents and family/whanau to complete for shared rooms. Four of the shared rooms were occupied by couples. Three of four unrelated residents had not signed a consent form to accept the remaining two shared room.<br>Admission agreements and general consent forms were appropriately signed by the resident or the activated enduring power of attorney (EPOA) where this has been activated. | Three out of four unrelated residents who occupy shared rooms do not have a signed consent on file for sharing the rooms. There was one sighted on file on the day of the audit. | Ensure that consent forms are completed and signed.<br><br>90 days |

| Criterion 2.2.5<br><br>Service providers shall follow the National Adverse Event Reporting Policy for internal and external reporting (where required) to reduce preventable harm by supporting systems learnings. | PA Moderate | There is an adverse events policy documented for the service that ensure that all adverse events/non-conformities are documented and effectively dealt with. This is underpinned by the National Adverse Event Reporting Policy. Review of resident progress notes evidence that two separate events related to pressure injury and bruise did not have a corresponding incident form completed by staff. Review of the incident forms showed that the SAC rating section was not completed for relevant incidents reviewed. Collated data does not reflect the SAC categorisation of the incidents as per policy. Interview with staff demonstrated lack of awareness of the SAC categorisation process. All the incidents that occurred in the month of October had not been evaluated or signed off by the clinical nurse manager as per policy.<br><br>Discussion with the assistant manager and clinical nurse manager demonstrated their awareness of their accountability with requirement to notify relevant authorities in relation to essential notifications. At the time of the audit the service did not have a facility log in for Severity Assessment Code (SAC) notifications to the Health Quality and Safety Commission.<br><br>Results of quality data are discussed in the staff meetings and at handover. | Two identified and documented resident events in the progress notes did not have corresponding incident forms completed (pressure injury and bruise).<br><br>All the events reviewed for the month of October have not been evaluated and closed off as per policy.<br><br>There is no demonstrable evidence of implementation of the National Adverse Events Reporting Policy as evidenced by: (a)All the incidents reviewed in the incident register and resident records do not link into the SAC categorisation as per policy, and (b)The facility does not have a current log in for the HQSC portal for entering SAC reports as indicated. | Ensure incident forms are completed for all adverse events.<br><br>Ensure that incidents are evaluated and signed off within the required timeframe as per policy.<br><br>Implement the National Adverse Events Reporting Policy.<br><br>60 days |
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| Criterion 2.3.4<br>Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services. | PA Moderate | There is a documented 2024 and 2025 education and training schedule that includes training related to clinical and non-clinical topics for all staff. Review of the training records demonstrated that training has not been completed as scheduled for 2024 and 2025. The only training that was completed included continence, understanding dementia, preventing dementia, fire training, motor neurone disease, palliative care, handwashing, scabies, and personal protective equipment. There is no evidence to demonstrate that the infection control coordinator has completed related training to keep themselves up to date with current best practice.<br>Competencies including medicine management, syringe driver, hoist / manual handling and interRAI have been completed as scheduled. | Staff training has not been completed as scheduled for 2024-2025.<br>The infection control coordinator has not completed training to keep themselves up to date with current best practice. | Ensure compliance that the training schedule is implemented.<br>Ensure that the infection control coordinator has completed training to keep themselves up to date with current best practice.<br><br>60 days |
| Criterion 3.2.3<br>Fundamental to the development of a care or support plan shall be that:<br>(a) Informed choice is an underpinning principle;<br>(b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan;<br>(c) Comprehensive assessment | PA Moderate | The care plans are individualised and reflect resident preferences; however, not all care plan interventions were documented in sufficient detail to guide the resident needs this is a continued short fall from the previous audit. Short term care plans are developed for short term needs such as infections, and additional resident needs such feeding regimes. The risk rating has been increased from low at | One hospital level resident with high falls did not document that the resident should be in the lounge in lazy boy for supervision and falls minimisation strategies are not well documented.<br>One hospital resident care plan does not document the GP suggestion for midazolam prior to care and does not link the challenging behaviour interventions to requiring two staff for | (i)-(ii) Ensure that care plans document care interventions needed.<br><br>60 days |

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| includes consideration of people's lived experience;<br>(d) Cultural needs, values, and beliefs are considered;<br>(e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia;<br>(f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated;<br>(g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention;<br>(h) People's care or support plan identifies wider service integration as required. | | the previous audit to moderate risk at this audit. The timeframe for implementation of the corrective action remains at 60 days. | care and that challenging behaviour is linked to care. | |
| Criterion 3.2.4<br>In implementing care or support plans, service providers shall demonstrate:<br>(a) Active involvement with the person receiving services and whānau;<br>(b) That the provision of service is consistent with, and contributes to, meeting the person's assessed | PA Moderate | A range of monitoring charts are available for staff to utilise. Monitoring charts reviewed were not all completed as required. Long-term care plans are formally evaluated every six months in conjunction with the interRAI re-assessments and when there is a change in the resident's condition. Evaluations include the degree of achievement | Seven of seven post falls incident forms do not document that neurological observations have been taken according to policy.<br>Restraint monitoring for one resident has not been documented two hourly as per the plan.<br>Daily site check, daily tube rotation, and monthly balloon checks for a | (i)-(iii) Ensure that monitoring of interventions is documented as per care plans.<br><br>60 days |

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| needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective;<br>(c) That the person receives services that remove stigma and promote acceptance and inclusion;<br>(d) That needs and risk assessments are an ongoing process and that any changes are documented. | | towards meeting desired goals and outcomes, are documented by the registered nurses | PEG are not documented as taking place. | |
| Criterion 3.4.1<br>A medication management system shall be implemented appropriate to the scope of the service. | PA Moderate | The service uses pharmacy pre-packaged medicines that are checked by the facility manager on delivery to the facility. All medications sighted were within current use by dates, and eyedrops had been dated upon opening. A system is in place for returning expired or unwanted medication to the contracted pharmacy. The medication refrigerator temperatures are monitored daily and within acceptable ranges  The medication room temperatures were not  monitored and documented daily. Medications are stored securely in accordance with requirements. | Room temperatures have not been monitored in both rooms where medication is stored. | Ensure that medication room checks are completed daily and are within appropriate range as per policy.<br><br>30 days |
| Criterion 3.4.4<br>A process shall be implemented to | PA Moderate | The medication management policy identifies all aspects of medicine | Three of twelve medication charts reviewed did not document allergy | Ensure that medication charts |

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| identify, record, and communicate people’s medicinerelated allergies or sensitivities and respond appropriately to adverse events. | | management in line with relevant legislation and guidelines. Prescribing practices are in line with legislation, protocols, and guidelines. Three-monthly reviews by the GP. Allergies were not always recorded in all medication charts sampled. | status. | document allergy status<br><br>30 days |
| Criterion 3.5.5<br><br>An approved food control plan shall be available as required. | PA Low | The main kitchen was observed to be clean. The three kitchenette fridges had stored food that was unlabelled and undated.<br><br>Residents and family/whanau interviewed expressed satisfaction with food service. | Three kitchenettes have undated and unlabelled food in the fridges. | Ensure that all stored food is labelled and dated.<br><br>90 days |
| Criterion 4.1.1<br><br>Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of peoples’ cultures and supports cultural practices. | PA Low | There is a Building Warrant of Fitness Report and Declaration (B-RaD). The management team stated that issues identified in this report have been rectified ( emergency lighting, the service lift, and the passenger lift).<br><br>There is an annual maintenance plan that includes electrical testing and tagging, residents’ equipment checks, call bell checks, calibration of medical equipment and monthly testing of hot water temperatures. Not all electrical items have an up-to-date test and tag, and not all medical equipment has an up-to-date calibration.<br><br>All corridors have safety rails that promote safe mobility. The service has shared rooms. One room with two | The service does not have a current Building Warrant of Fitness.<br><br>Testing and tagging is not up to date for a vacuum cleaner and two hoists.<br><br>Two hoists have not been calibrated within the last year.<br><br>One shared room for two unrelated residents (room 31) does not provide privacy as there is no curtain or other physical barrier between the beds. | Ensure the service has a current Building Warrant of Fitness.<br><br>Ensure equipment is tested and tagged annually as per schedule.<br><br>Ensure equipment is calibrated as per schedule.<br><br>Ensure shared bedrooms can provide privacy for those residents occupying them. |

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| | | residents (not related to each other) is not able to provide privacy for the individual residents in that room. | | 90 days |
| Criterion 4.1.2<br>The physical environment, internal and external, shall be safe and accessible, minimise risk of harm, and promote safe mobility and independence. | PA Moderate | Corridors are spacious, and residents were observed moving freely around the areas with mobility aids where required. There is safe access to all communal areas, however, the fire exits were not always clear of obstacles. | The upstairs fire escape was blocked by a chair on both days of the audit. The assistant manager informed that this was to stop residents accessing the fire escape. | Ensure that egress is not blocked.<br><br>30 days |
| Criterion 5.2.4<br>Service providers shall ensure that there is a pandemic or infectious disease response plan in place, that it is tested at regular intervals, and that there are sufficient IP resources including personal protective equipment (PPE) available or readily accessible to support this plan if it is activated. | PA Moderate | Sylvia Park Rest Home and Hospital has a documented outbreak, pandemic, and infectious disease response plan in place. There are two outbreak bins located in an accessible room for staff. Review of the outbreak resources on the day of the audit confirmed that there is no process to regularly check the supplies. The PPE supplies in the bins were documented as last checked on 25 May 2021.<br>The list on the bins did not correspond with the PPE stored inside the bins. There were no gloves, masks, paper towels, and rubbish bins in stock to effectively manage an outbreak or pandemic if activated. The contents sighted in the PPE bins were past their use by dates. Disinfectant wipes, sanitizer, yellow gowns, and barrier creams were all expired. | There is no documented process of checking outbreak supplies.<br>The two outbreak bins sighted did not contain supplies as listed on the bin label.<br>PPE stocks stored in the bins were past their use by dates. | Put a processes in place to check outbreak supplies.<br>Ensure that outbreak bins are stocked as per checklist.<br>Ensure that stock for use in the event of an outbreak has not expired.<br><br>60 days |

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| Criterion 5.5.1<br>Service providers shall ensure safe and appropriate storage and disposal of waste and infectious or hazardous substances that complies with current legislation and local authority requirements. This shall be reflected in a written policy. | PA Moderate | There are policies regarding chemical safety and waste disposal. However, three chemical bottles sighted in the upstairs cleaners' room and on the trolley did not have manufacturer's labels on them. There were no material safety data sheets (MSDS) in the cleaners' room downstairs. Although there were MSDS in the upstairs cleaners' room, these did not match the provider and the chemical labels on the bottles in use by the cleaners.<br>Chemicals were not stored in locked rooms and cupboards. There were chemicals stored under the sinks of the three kitchenettes where the cupboards did not have a locking system in place to maintain chemical safety and minimise the risk for residents.<br>The service has communal toilets available in all areas for residents to access, however one of the toilets is also a slice room. | There were no material safety data (MSD) sheets in one of two cleaners' rooms; and material safety data sheets did not match the name of the chemical provider or the chemical labels on the bottles in use by the cleaners (noting that two bottles in use were not labelled).<br>There were chemicals stored under the sinks of the three kitchenettes where the cupboards did not have a locking system in place to maintain chemical safety and minimise the risk for residents.<br>An upstairs designated disability toilet has a toilet with disability access, but it also contains the sluice sanitiser and a sluicing sink, and empty laundry bins. | Ensure that MSD sheets match manufacturer labels and labels on chemical bottles in use.<br>Ensure chemicals are securely stored.<br>Ensure the sluice is not used as a resident toilet and is not a designated and labelled disabled toilet.<br><br>60 days |
| Criterion 5.5.2<br>Service providers shall ensure that people, visitors and the workforce (both paid and unpaid) are protected from harm when handling waste or hazardous substances. | PA Moderate | There are designated cleaners' rooms where chemicals can be decanted for use on the cleaner's trolley. There are designated sluice rooms with sanitizers in each unit. However, the cleaners' rooms and sluice room upstairs (which also has a sluicing sink, communal toilet, and laundry | There is no supply of personal protective equipment in the cleaners' rooms and sluice rooms as sighted on the day of the audit. | Ensure that there is supply of PPE for staff accessible at the point of need like cleaners' and sluice rooms. |

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| | | bags in the same room) did not have personal protective equipment for staff to use. | | 60 days |
| Criterion 5.5.3<br><br>Service providers shall ensure that the environment is clean and there are safe and effective cleaning processes appropriate to the size and scope of the health and disability service that shall include:<br>(a) Methods, frequency, and materials used for cleaning processes;<br>(b) Cleaning processes that are monitored for effectiveness and audit, and feedback on performance is provided to the cleaning team;<br>(c) Access to designated areas for the safe and hygienic storage of cleaning equipment and chemicals.<br>This shall be reflected in a written policy. | PA Moderate | There are documented cleaning schedules for daily and periodic cleaning. These were accessible in the cleaners' rooms. Inspection of the environment on both days of the audit demonstrate that cleanliness has not been maintained. The cleaners' rooms had stained flooring that appeared to be moisture laden, and dust settled on surfaces and window seals. The nurses' station and storage cupboards had layers of settled dust.<br><br>It was observed that one of two cleaners' rooms had leaking fluids / chemicals causing moisture, discolouration to the flooring and a musty odour in the room. There was a container collected leaking liquid with algae settled in it.<br><br>The outcome of the internal auditing processes (completed August 2025) demonstrates that cleaning schedules have been maintained for daily and periodic cleaning. | Inspection of the environment demonstrates that the cleaning standards have not been maintained. This includes the cleaners' room downstairs; nurses station and storage cupboards in the hallways.<br><br>The cleaners' room has leaking chemicals / fluids causing moisture and discolouration to the floor with algae settling in containers that are collecting the fluids. | (i)-(ii) Ensure that cleaning standards are maintained.<br><br>60 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection can also be rated as having a continuous improvement.  A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment.  The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant subsection by looking at the code.  For example,  Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this audit.

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End of the report.